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ORIGINAL DEPARTMENT.

OUR CLINICAL TEACHERS.

I.

LEWIS A. SAYRE, M. D.

With the present number of *THE REPORTER* commences a series of brief notices of the prominent clinical teachers of America. These sketches are intended more as introductions than biographies. General illustrated literature is not more universal than its ignoring of living and illustrious medical men. We propose, therefore, to illumine our pages with the faces of some of these noble workers, who, almost self-ostracized from social life, are visible only in the shadowy rooms of the sick or the limited area of the lecture-room.

An active, earnest, and popular clinical teacher is the subject of our initial paragraphs: **LEWIS A. SAYRE, M. D.**, Professor of Orthopedic Surgery in the Bellevue Medical College, and Surgeon to Bellevue and Charity Hospitals, New York.

Dr. Sayre, like most men of note, is self-made. His practice commenced in that mysterious maze of alleys and tenements, known only to a large city. Persistent, manly endeavor has possessed him of one of the most lucrative practices in the country.

To a commanding presence Dr. Sayre adds a manner of speech that is plain, forcible and attractive. While being eminently practical in his clinical teaching, he abounds in illustration and comparison, which, like the well-drawn chart to the strange traveler, enables him to impress the points and clear up the angles and crossings of his discourse. He adds mechanical genius to operative skill, has the power of winning the confidence of his patients, and is a decided favorite with his classes.

Dr. Sayre's hearty, spontaneous and gener-

ous nature has not prevented his professional life from being characterized by fearlessness and determination. The "Ruppaner case," and the "alleged malpractice suit of Walshe vs. Sayre," illustrates these qualities. In the latter case, using the words of Professor Gross, "Dr. Sayre achieved a great triumph, in which every honorable professional man in the country rejoiced."

Dr. Sayre is yet in the prime of life, with every promise of many years continuance of his great professional usefulness.

COMMUNICATIONS.

PUERPERAL CONVULSIONS.

By G. N. DUZAN, M. D.,

Of Zionsville, Indiana.

While the phenomena of puerperal convulsions point unmistakably to the cerebro-spinal centers as the anatomical seat of morbid action, the etiology and pathology of the disease are not clearly demonstrated. Hence the diversity of opinion existing concerning its essential nature.

Some writers, eminent as authorities, maintain that there is a specific *materies morbi* circulating through the organism, morbidly impressing the nervous system, and thus exciting the phenomena peculiar to puerperal eclampsia.

BRAUN has declared that the convulsions caused by uremic intoxication in acute Bright's disease, and puerperal convulsions, are identical. Other writers, equally respectable as authorities, claim that the disease is caused by deranged innervation of the nervous centers, from the disturbing influences of the gravid uterus upon the circulatory and assimilative organs.

CAZEAUX entertains the notion that albuminuria is the predisposing cause of the disease, by begetting a peculiar excitability of the cerebro-spinal centers. This notion is deduced from the fact that albumen is almost invariably discoverable in the urine of eclamptic women.

While retention of urea in the blood and excessive loss of albumen may beget a morbid excitability of the cerebro-spinal centers, yet this fact can not be accepted as conclusive evidence in establishing an intimate relation of causality between Bright's disease and puerperal convulsions.

In all cases of acute Bright's disease albumen is discoverable in the urine, yet there may not be any eclamptic phenomena. Urea has been injected into the blood and proved to be wholly innocuous; no symptoms of convulsions followed its introduction into the circulation. During puerperal convulsions the functions of the cerebrum and tubercula quadragemina are suspended, while the functions of the cerebellum, medulla oblongata, and spinal cord are greatly intensified. Could a specific poison circulating through the organism impress the several parts of the nervous system so dissimilarly as to abolish the functions of one part and violently increase the functions of another?

The phenomena of puerperal convulsions seem to observe a regular order of succession. The cerebrum and tubercular quadragemina are first quelled into temporary death or oblivion, after which the cerebellum, medulla oblongata and spinal cord are successively affected, becoming the seats of intense, though irregular, evolution of power. This contrasted condition of the various parts of the nervous system and the regular order of succession in which they become affected, constitute a notable peculiarity of the disease, in the investigation of which we will probably find a solution of the etiological question.

That the manifestation of the vital properties of an organ is proportionate to its supply of arterial blood is a physiological verity. That venous hyperæmia of an organ is incompatible with the manifestation of its vital properties, is also a physiological truth. These facts will, perhaps, enable us to comprehend the etiology of the disease under consideration.

The suspended function of intellection and loss of vision are the effects of *venous hyper-*

semia of the cerebrum and tubercular quadragemina, while the intense though irregular evolution of power exhibited by other parts of the nervous system is the effect of arterial hyperæmia of cerebellum, medulla oblongata and spinal cord.

During the convulsion there is interruption of the respiratory function, the oxygenation of the blood ceases, the whole sanguine mass becomes carbonated, the cerebellum, medulla oblongata and spinal cord then fail to innervate the muscles connectively, because of the deoxidation of the sanguine mass and conversion of arterial into venous blood. After convulsive action ceases, the lungs resume their function of eliminating carbonic acid and oxygenating the blood, and for a time the brain and spinal cord awaken to a renewal of intellectual and organic functions.

The curious and notable fact of the cerebrum and tubercula quadragemina being in a state of venous hyperæmia while the cerebellum, medulla oblongata and spinal cord are in a state of arterial hyperæmia, demands an interpretation not hitherto expressed.

Anæmia of the heart from excessive loss of albumen, affecting particularly the right side, will cause a congested state of its cavities, and an accumulation of blood in the cerebral veins, —or venous hyperæmia of the cerebrum. The mechanical influence of the gravid uterus, by thrusting the intestines upward, and compressing the abdominal vessels and checking the descent of arterial blood, will cause a determination of arterial blood to brain and spinal cord.

The anæmic and overloaded condition of the right side of the heart interrupts the return of venous blood from the cerebral vessels while the upward arterial current is arrested in the medulla oblongata and cerebellum by the distended condition of cerebral veins and tortuous course and obtuse angled bifurcations of the arteries of the base of the brain.

The checking of the upward arterial current at base of brain causes arterial hyperæmia of the cerebellum, medulla oblongata and spinal cord and that increase of their vital properties which characterizes puerperal convulsions.

If the foregoing views respecting the etiology and pathology of the disease be true, the treatment is clearly indicated. The overloaded right auricle and ventricle should be relieved by taking blood from the arm, after which the cerebrum will resume its function of intel-

lection, if effusion has not occurred. The contents of the gravid uterus should be expelled as speedily as possible, and thereby relieve the compressed abdominal vessels, thus removing the cause of determination of arterial blood to the brain and spinal cord.

Digitalis, by diminishing the frequency of the heart's action and giving tone to cerebral vessels, will have an admirable effect in preventing effusion and reestablishing the cerebral circulation. The hydrate of chloral, by contracting the cerebral vessels, and thus controlling the hyperæmia, will doubtless prove an efficient agent in the future treatment of puerperal eclampsia.

NOTES OF PRACTICE.

By H. L. W. BURRITT, M. D.

FOREIGN BODY IN THE BLADDER.

Mr. B—, set. 56, had been in the habit, for years, of using a gum catheter for the relief of a spasmodic stricture, and the instrument last used, No. 4, had become so weakened that in attempting to withdraw it, it broke leaving three inches in the bladder. Great pain and irritation followed, aggravated by extreme anxiety and nervousness. I drew off the urine, passing without difficulty a No. 8 catheter, and gave relief by small doses of morphine. A suitable instrument not being at hand, and having to wait for the manufacture of one in New York, I tried, using the largest instrument—(bougie), No. 12—I had, and directed the patient to retain the water for as long a period as possible, and to bend forward at an angle of 45° when urinating, hoping the point of the broken catheter might turn and be engaged in the urethra. To my surprise, and the delight of my patient, while passing urine (after four hours' retention), the point was felt in the urethra, and the broken piece extracted, with little effort, on the second day after the accident, and after using the bougie the fourth time. One peculiarity of the case was, the use, on a second trial, without pain or difficulty, of so large sized an instrument in a spasmodic stricture, as this evidently was. All the instruments I have seen are too clumsy and complicated for extraction of foreign bodies from the bladder. Would not forceps, nearly straight, of the size of No. 10 catheter, perfectly smooth when closed, answer?

SCARLATINA.

CASE 1.—C. T., girl of ten; light complexion and delicate health. Father says he hung his coat on the same nail with a fellow workman, whose children had the disease, and took his daughter in his arms on coming home at night, and thinks he gave her the complaint in that way—the only possible exposure. Saw her on first day of the eruption, which was apparently light; pulse, 120; tenderness in the throat; child sitting up. Ordered *bi. tart. potass.* ʒj to a glass of lemonade; tablespoonful every three hours, until the bowels had moved once freely; cold ice water for drink, and applied on a light cloth to the neck. Second day—Intense heat and redness of the skin; pulse, 169; light delirium; bowels not moved; treatment continued; room ordered to be kept cool. Third day—About the same. Bowels moved once; urine free; delirium continued; same treatment. Fourth day—Pulse, 160; delirium and extreme restlessness; throat and submaxillary glands swollen and swallowing painful. The application of ice water was so violently resisted that it had to be left off, and the following was substituted *daily*: *Ext. belladonna, ext. aconite, chloroform, tinct. opii, a. a. ʒss; iodid. potass ʒij.*—M. This seemed to quiet the restlessness very much; other treatment continued; light mutton broth and milk principal diet. Fifth day—Eruption fading; pulse, 150; less delirium; bowels moved once in 48 hours; urine free with deposit; glands all badly swollen around the throat; the whole body bathed (as it had been daily) with a weak solution of cool saleratus water. The case went on to a very slow but satisfactory recovery. The liniment seemed to relieve all the throat difficulty, and no sequelæ of nasal or aural abscesses.

CASE 2.—Three cases in the same family; all very severe. One of the three, of light complexion, a delicate girl of seven years, broke out at 9 A. M., with light rash and accompanied by vomiting and purging; feet cool; stupes of capsicum to the lower extremities and ice water to the neck and head were applied; 12 M.—child in a violent delirium, evidently a hopeless case; weak milk punch given; warm bath to the feet and ice over the whole cranium; pulse small, 160; feet and lower limbs became warm after some time, but no impression was made; death in 24 hours after the child was walking around the room. Now what could cold effusion or any treat-

ment do in a case like this? It may be unjust, but it seems to us that those who talk of seeing forty or fifty cases of this disease and *no mortality*, must live in a section favored by mild types of the disease, or call cases like mine meningitis, etc., and so *lose no patients* with scarlatina. Not that I would depreciate the cold treatment, for I use ice in every bad case of croup, or of malignant sore throat (alias diphtheria) and consider it one of the specifics, but I do lose some of my patients, I am sorry to say, even then.

CHLOROFORM.

Reading, in THE REPORTER of Dec. 10, the case of Dr. DAWSON, at the Cincinnati Hospital, and the discussion thereon, leads me again to recommend the use of alcoholic stimulants, in all cases where chloroform is administered, as the best preparative agent for safety, far better than food, as less objectionable to vomiting, and giving to rallying nerve force a stand-point resistance. I have used this precaution in thousands of cases, and never yet have read of a fatal case where it was tried, and *challenge* the production of one where death was *immediate* following its use. This course is certainly indicated where it is judged best to operate without waiting for decided reaction, in extensive mutilations from severe injuries. I see, by reported cases, its use is common in some localities, and hope it may become universal and remove the objection to the use of this indispensable anæsthetic.

TETANUS.

In THE REPORTER of Oct. 29 I notice Dr. VANDERPOEL criticises my case of tetanus, and mistakes the courtesy of free discussion by claiming the failure of strychnia to cure as a mistake of dose and a want of courage in the physician. The dose— $\frac{1}{4}$ gr.—I have (with many others) often given *three* and *four* times in 24 hours, without injury, and repeatedly taken myself, without being especially "*terrified*," and I "*ended the experiment*" in my case, or it would have *ended* the patient. Tetanus, I fear, in all typical cases occurring before or on the eight day from the injury, will continue to be a fatal disease for some time yet, in spite of the specifics of strychnine, and lobelia, etc. Dr. Vanderpoel's cases were very interesting and instructive, and deserving of our thanks. "*Invariably successful*" is a strong term for any new remedy in this disease, and I beg leave to hold a contrary opinion.

HOSPITAL REPORTS.

UNIVERSITY OF PENNSYLVANIA.

Clinic of Prof. D. HAYES AGNEW, M.D.

February 4, 1871.

[REPORTED BY DE F. WILLARD, M.D.]

Luxations of the Humerus.

GENTLEMEN—We have present this morning several cases of dislocation of the shoulder-joint, which I trust I shall be able to restore before you, to their proper and normal positions.

The first is this colored woman, who says that she received a fall some four days since, and that she has been unable to use her left arm since that accident.

Upon examination we find that her elbow stands off from the side of her thorax, and that it cannot be brought in apposition without causing pain; that there is also a large prominence in the axilla, and that a depression exists beneath the acromian process of the scapula to such an extent that the fingers can be hooked beneath it, the normal rotundity of the shoulder being thereby diminished, and the deltoid muscle, which covers the joint in front, behind and upon the external side (arising, as it does, from the outer third of the clavicle, from the acromian, and from the whole length of the lower border of the spine of the scapula, and passing down to be inserted to the middle of the outer side of the humerus,) is very markedly flattened.

Our diagnosis could not be otherwise than that of dislocation, especially when we also add the readily perceived symptoms of lengthening of the limb, loss of power, and inability to place the hand upon the sound shoulder while the elbow is held against the breast.

This, then, is a luxation of the head of the humerus into the axilla, which is the most common position assumed when it leaves the glenoid cavity, and is known as the axillary dislocation. The other varieties are the thoracic or sub-clavicular, where the head of the bone is found resting upon the second and third ribs to the sternal side of the coracoid process, beneath the great pectoral muscle; and the scapular posterior, where the head rests upon the dorsum of the scapula.

Now let us study this axillary dislocation from a mechanical point of view. This head has been forced from its position by some violence, and is in an uncomfortable position, from which it would be glad to escape did not some obstacle prevent. Let us then remove the obstacle, and the bone will itself seek its normal resting place. If then we recall our anatomy we will remember that this glenoid fossa has an elevated rim, and that when the bone left this cup it slipped over this ridge and was

then spasmodically drawn up against the lower surface of neck of the scapula by the action of the supra spinatus muscle. You will remember this muscle as arising from the supra-spinous fossa, and running across the top of the joint to be inserted into the great tuberosity, and you will immediately recognize the fact that its fibres must be put greatly upon the stretch by such an accident, as are also those of the deltoid, though not to such an extent. The latissimus dorsi and pectoralis major would be relaxed.

Now, as I have said, this is to be regarded as a mechanical affair, and at once we see that this spasmodic contraction must be counteracted and the head relieved from its locked position against the rim by being brought clear of the lower edge of the cavity in a manner which I shall presently show you. When this is done, you can readily see that it will assume its original position by the simple contraction of the muscles; and now you can understand the benefit of anatomy, since, without a comprehension of the exact difficulty, all your force might be expended in the wrong direction, and you might fail, while a good anatomist would apply both his common and acquired sense and succeed.

When the humerus is dislocated forward underneath the pectoral muscle and below the clavicle, this supra-spinatus and deltoid are also put upon the stretch, and the infra-spinatus even more so, while the pect. major is relaxed. Remember, then, these muscles also, and consider that the extended ones are those whose resistance is to be overcome.

In the scapular form, where the head forms a tumor upon the inferior fossa of this bone, the sub-scapularis, the supra-spinatus and the teres and pectoralis major will be put upon the stretch, while the deltoid and infra-spinatus will be relaxed.

In the second variety the symptoms will be the same as those of an axillary dislocation, except that the limb will be shortened instead of lengthened, which is also true of the posterior luxation, in which latter, however, the elbow is found in a decidedly different position, being thrown forward and against the chest.

It is but seldom that you will meet with any form except the axillary, yet an occasional case will occur.

All varieties are usually occasioned by violence inflicted either upon the shoulder, or through the intervention of the upper extremities as in falls upon the hands, the cases resulting from spasmodic contraction of the muscles, or from preternatural relaxation of the ligaments being exceedingly rare. When we consider the shallowness of the glenoid cup, even when deepened by its ligament, it is a matter of surprise that this accident is not of more frequent occurrence, and such would be the case were it not for the moveability of the scapula and the strength imparted to the joint by the surrounding muscles. There is the deltoid, the sub scapularis

the two teres, the infra spinatus, and the coraco brachialis superficially, while beneath, and more directly connected with the articulation, are the long head of the biceps, as it runs from its origin at the upper edge of the fossa to be inserted into the tubercle of the radius; and the supra-spinatus running from the supra-spinous fossa to the greater tuberosity of the humerus. All these, of course, add greatly to the support, especially when they are tense and contracted, and it is quite probable that a majority of the cases of displacement occur while these muscles are off their guard.

The diagnosis should not be difficult when the symptoms which I have enumerated are present; yet you will sometimes find yourselves puzzled, and mistakes are constantly occurring, especially when a blow has temporarily paralyzed the deltoid, thereby causing flatness of the shoulder; yet in such cases there is no tumor in the axilla, and the arm is of normal length. The greatest difficulty will occur when there is a coexisting fracture; but here, as in all doubtful cases, ether will usually enable you to settle the question; and here let me reiterate, as I have so often done before, that in every case of doubt, whether of fracture or dislocation in any part of the body, an anæsthetic should always be given.

Complete anæsthesia is the most convenient method of producing that entire muscular relaxation which is invaluable in the reduction of a dislocation, and while the patient is being etherized I will speak of the means employed for such reduction.

In the first place, ether; then, remembrance of the anatomical facts to which I have called your attention, since it is only by overcoming the spasmodic contraction of these extended muscles that you can succeed—and thirdly, reason and judgment.

All dislocations of the head of the humerus are eventually treated alike, since all can be readily converted into the axillary variety, by the manipulation of raising the elbow and carrying it slightly backward, the capsular ligament being always freely lacerated. This accomplished, it can be brought into its normal cup either by the method (the one I usually prefer) of elevating the arm along side the head, and making extension upon it while support is given to the acromion by the heel or hand of the surgeon, the head being thus drawn directly upward into the cavity; or by the more common one of placing the heel in the axilla as a fulcrum, while extension is made upon the arm until the head has cleared the rim of the fossa, when it is thrown into position by carrying the arm across the patient's chest.

The same principle as in the latter is involved when the patient is made to sit and the knee placed in the axilla, or where he is suspended over a door as was formerly sometimes practiced.

As I have said, we have usually but to relax the stretched muscles when the bone will be itself drawn into position, and it was acting upon this fact that SMITH introduced his method of rotation and elevation, since the supra and infra spinati were the ones principally at fault. This consists of elevation of the elbow along side the head, thus relaxing the supra spinatus, carrying the hand outward to produce rotation and thus relaxation of the infra spinatus, then bringing the elbow down while this rotation is maintained, and lastly "leverage and elevation of the head of the bone into the glenoid cavity by carrying the arm over the chest and, at the same time, reversing the rotation."

By some of these methods you will seldom fail if the displacement be recent, but in old cases much trouble may arise. Whenever a luxation is reduced it should be confined in position for a few days by a bandage, after which the joint should be rubbed with some stimulating liniment for several weeks.

[The woman being thoroughly etherized, the arm was carried up almost in a line with the side of the body, and then rotated outwardly, thus relaxing both supra and infra spinati, where the acromion being fixed by the foot of the operator, a slight pull was sufficient to slip the head to its normal position with a marked click. A Velpau bandage was applied and no further difficulty experienced.—Dr F. W.]

CASE II.—M. C., *et. 60.* This is a case of injury inflicted eleven weeks since, and is, therefore, one of those clinical cases which are most difficult of reduction. He presents all the symptoms which I have enumerated as characteristic, and has also tingling in his fingers from pressure of the head of the bone upon the axillary nerves, and also cedema from interference of circulation in the corresponding veins.

Now, here we may expect much more trouble than in the former case, since not only has there been time for repair of the rent in the capsular ligament, but adhesions may also have so thoroughly bound the head of the bone to the under face of the neck of the scapula that a new socket may be partially formed, while there will undoubtedly be such an amount of deposit about the axilla as to render severe manipulation dangerous to the safety of the axillary artery or vein. Such adhesions should first be thoroughly broken up by rotation previous to any attempt at reduction, but it must be done with great care, and no extreme force should ever be applied, since irreparable injury may result. Great patience will be required, and every method must be tried, until at last the right one shall be found. Traction should always be slow, steady and persistent, since such a power is much more effectual than a fitful, jerking pull.

I now gently move the arm in every direction, and you can hear the adhesions giving way; and as all are now loosened, I will try the same method

which was employed in the preceding case, *i. e.*, pulling the head directly upward into its position. [Attempt here made.] I have failed to restore it, although I have used as much force as is prudent; but there are numerous other methods yet to be employed. I will next try the old method of placing the heel in the axilla as a fulcrum, but this is also as unsuccessful as the first; though the patient is thoroughly relaxed. I will now again loosen all the adhesions, and try the manipulation method as described a few moments since, but this also fails.

I try them all again—and also all the other proposed methods—and yet the head of the bone is still in the axilla. Now you will say, "cannot you apply more force?" Certainly I can, and I can also lacerate that axillary artery at the same time, as has been done upon several occasions. Force must be used with discretion. I could apply enough to tear the man's arm from his body, but we are not anxious to study his pathology just at present. The pulleys were formerly often used, and are sometimes of benefit; but they require caution, and I think we shall yet succeed without them.

Let us look at this matter without following any special rules—study it as I have told you. The head must be drawn out of the axilla, and it must be brought outward to the glenoid fossa. The first indication I will fulfill by attaching a fillet to the arm above the elbow and giving it to two assistants, who shall pull in a direction outward and downward at about an angle of 50° from the body, while the scapula will be held in position by a sheet which shall be passed around the body and carried to the opposite side by two more assistants. Another will steady the acromion, while I will fulfill the second condition by placing a towel in the arm-pit in such a manner that I can draw directly upon the head of this bone when the proper moment arrives, which will be when the head has cleared the rim of the cavity; and now I can feel that it has done so, and while I thus pull the head outwardly the assistants will carry the arm across the chest, being careful to continue the traction until such a position is fully reached, when they will loosen their hold; and, as you plainly see, our object is accomplished, the head is in the glenoid cavity, the tumor has disappeared from the axilla, and the normal rotundity of the shoulder is restored. The patient will be put to bed and a retaining bandage applied.

You will see that considerable force was used, yet you doubtless also noticed that my left hand was constantly in the axilla to regulate and guard against undue efforts. But suppose we had failed this time also? Then we would have used the pulleys carefully, and at last even a Jarvis' adjustor, which is a most powerful instrument, but which will also even fail in some few cases. Of course all proper means should be employed, since the use-

fulness of the member would be greatly impaired should it remain in this abnormal position; still, rather than inflict violence upon the artery I would desist, especially in an elderly person, and try to gain as much motion as possible in the new socket which would be formed.

CASE III.—Is a man 45 years of age, who says that he received a "bruise" upon his shoulder some four or five weeks since, and that he has since been treated by liniments and electricity for loss of power in the right arm, no dislocation having been diagnosed, yet when I place my hand upon this shoulder I am sure that such an accident has occurred, although the symptoms are not as marked as in other cases, still, when he is fully etherized, they will be more apparent.

[The deformity was easily removed by the same method as that employed in the first case; but as soon as released it immediately slipped out again into the axilla, through the rent in the capsular ligament, when it was again restored and confined by a bandage, so that no repetition might occur.—DeF. W.]

MEDICAL SOCIETIES.

CINCINNATI ACADEMY OF MEDICINE.

February 28, 1871.

By C. H. BUCKNER, M. D.

[REPORTED BY J. W. HADLOCK, M. D.]

Foreign Bodies in the Larynx.

Mrs. G., of Ky., came under the treatment of Dr. TALIAFERRO and myself, last November. History—"Age fifty-five, married twice, and had borne four children; menstruation ceased at fifty-three. Has never enjoyed very good health. About four years ago a slight cough, which she had had for several years, became suddenly very severe, coming on spasmodically and continuing until she was completely exhausted. Anodynes gave some temporary relief, but the cough was the same when the effect of the medicine passed off. After a time her kidneys were affected, and she suffered great pains in the back and loins. There was frequent desire to micturate, and blood and mucus passed with the urine.

Under the treatment of her physician the severity of these symptoms was relieved. The cough still continued, although the paroxysms were not so frequent; she again grew worse and concluded to visit this city for advice. When she first came under our treatment her condition was truly deplorable. The severe paroxysms of cough came on three or four times day, but her greatest distress was incontinence of urine. She said that for a few months prior to her visit to us "the flow of urine took place at every coughing spell," but now it

dribbled constantly, keeping her perfectly miserable. She had been considerably reduced in flesh by her sickness, but still was not emaciated.

The urine presented the appearance of being mixed with milk and blood. After standing a while, a thick, whitish deposit, constituting about one-third the whole mass, took place. This deposit proved upon examination to consist largely of the urates and phosphates, and apparently a small quantity of blood and mucus. Reaction normal, sp. g. 1030.

Upon attempting to explore the bladder, Dr. Taliaferro discovered a stricture situated at the opening of the urethra, and another at the neck of the bladder. It was only after several efforts that he succeeded in introducing a small-sized sound. Mrs. G. thought her "kidney trouble," as she termed it, was the result of the severe cough, and if her supposition was not entirely correct, it was undoubtedly true that her urinary difficulty was much aggravated by the cough. Auscultation did not reveal to us any tubercles in the lungs, and the spasmodic character of the cough led us to conclude that it was asthmatic. Our patient was placed upon a stimulating and anodyne expectorant for her cough, and the stricture was gradually dilated.

A few days afterward, during a severe paroxysm of coughing, she felt something in the mouth which she supposed came from the wind-pipe; this was saved and exhibited to us at our next visit. A small portion of this substance we here present to you for inspection under the microscope. Drs. Taliaferro and Carson have both made a microscopical examination, and pronounced it to be of vegetable origin. After expelling this substance, Mrs. G. still had a slight cough, but its violence and paroxysmal character were entirely gone, and she expressed herself as feeling almost well. The stricture was now rapidly cured, and when she left for home she could retain her water for several hours, although there was still an occasional dribbling, which compelled her to wear the urinal as directed by us.

Mrs. G. was unable to recollect when she inhaled the foreign body, but thought it might have occurred while renovating a straw bed, and its appearance when first removed indicated that it might have been the beard or capsule from some of the small grain.

This case is an illustration of the difficulty in making a correct diagnosis in similar cases.

Before the invention of the laryngoscope, the stethoscope was the only instrument used in physical explorations, to determine the presence of foreign bodies in the larynx and trachea; but this in numerous instances gave no information.

The laryngoscope, however, has been to the phy-

sician as important and valuable an aid in diagnosing obscure diseases of the air passages as the ophthalmoscope has in revealing deep seated affections of the eye.

Several cases are recorded of foreign bodies in the larynx and trachea, the presence of which was unknown to the patient and was not suspected by the physician until some accident, or an effort of nature, expelled the offending substance from the wind pipe. On page 403, vol. I, of the *London Lancet* for 1829 is mentioned the case of a boy admitted into the Samaritan hospital who was suffering with croupy cough. After an emetic of ipecacuanha wine he vomited up a cherry stone, and the cough was at once relieved.

An interesting case is given in the *Medico-Chirurgical Review*, vol. XXVIII, taken from Porter's work on the surgical pathology of the larynx and trachea. "Mr. Porter was requested to examine the body of a child who was supposed to have died from being thrown from a gig, and from one of the wheels having passed over the chest; she had so far recovered from the accident that she walked home without assistance, although from the moment of the accident her cough had been croupy; these symptoms continued for 38 hours, when she expired in a paroxysm of convulsive cough; on dissection the thorax and its contents were found uninjured, but on opening the larynx there was discovered part of an almond shell, its rough and broken edge entangled in the rima-glottidis, and placed in such a manner that it effectually closed up the aperture for the transmission of air." The presence of any foreign body in the windpipe was not suspected in these cases, and their history very naturally suggests the conclusion that many cases of sudden and fatal croup as supposed, were due to the presence of a foreign body in the larynx or trachea.

In the ordinary acts of deglutition the epiglottis is a faithful sentinel, effectually protecting the air passage, but any emotion, as surprise, anger or fear, causing a sudden inspiration, will be likely to draw into the windpipe any foreign body which may be within the current of air; but small particles of dust and other light substances floating in the air may pass into the larynx during ordinary inspiration while talking. The experiments of MAGENDIE upon inferior animals, from which he had removed the epiglottis, have seemed to indicate that this process was not absolutely necessary to protect the air passage in deglutition in these animals.

BARON LARREY, in his *Memoirs of Military Surgery*, mentions the case of a soldier who was wounded at Aboukir, in Egypt, 1807: "The ball entered at the angle of the jaw, passed obliquely across the throat and out at the opposite side of the neck. The base of the tongue was split and the

epiglottis was cut off, spit from the mouth and showed to the surgeon who came to his assistance. When he first attempted to swallow, he was seized with a convulsive cough attended with vomiting.

Larrey succeeded in introducing an œsophageal tube by which the man was nourished until the wound healed, after which he was able to swallow properly prepared food without the œsophageal tube. This case is reported in Prof. FLINT's work upon physiology, and the accident is reported to have occurred to Gen. MURAT, but this is evidently a mistake, as Larrey mentions the case as being without precedent. He also reports in the same chapter the case of Gen. Murat, who received in the same battle a somewhat similar wound, but does not mention the removal of the epiglottis in his case. The ball entered at the angle of the jaw, penetrated into the mouth, removing a portion of the masseter muscle, and going obliquely backward and downward, it probably injured the ninth pair of nerves. Deglutition became very difficult, and the voice hoarse and interrupted.

I take occasion to mention these two cases in order that a slight mistake in history may be corrected. Larrey's case, and other cases as reported by Profs. DALTON and FLINT, indicate that although the epiglottis is essential, it is not absolutely necessary to prevent the passage of foreign substances into the larynx.

Some of the conclusions arrived at by Dr. KRISHABER in the study of deglutition by t auto-laryngoscopy, as presented in a note to the French Academy of Science, in July, 1835, are: "In gargling, the larynx being widely open, a large quantity of fluid finds its way into the vocal organ." "An alimentary bolus may be tolerated in the larynx as far as the vocal cords, and even in the interior of the trachea." "The sensibility of the trachea to the impression of foreign bodies is infinitely less than that of the larynx."

Hard and cold bodies, as for example, a sound, is not tolerated in the respiratory passages; while any soft body which can adhere to the mucous membrane, and has a temperature like that of the parts touched, is easily tolerated in the respiratory passages, and kept in the trachea many minutes without producing the slightest cough.* Prof. Flint very truly remarks that these conclusions are opposed to common experience.

If, however, a foreign body be fairly lodged in one of the laryngeal ventricles, it has been known to remain there for many years without much inconvenience. The same may be said when it is fixed low down in the trachea, or in one of the bronchi;† but even in such instances the life of the patient is in great danger. If inflammation

*Flint's Physiology.
†Porter.

does not ensue, the foreign body may be displaced at any moment, and by my moving up and down the wind-pipe, or by passing into the lungs, produce convulsive cough and death.

As the laryngoscope will enable the physician who is expert in its use to determine the presence of a foreign body in the larynx, and even in some instances as far down as the bronchi, in suspected cases, it becomes an important question as to the propriety of an operation for its removal. I think most surgeons will agree with me in the suggestion that whenever the body is known to be hard and uneven in its surface, or of such size or character as to endanger life, should it be dislodged and pass into one of the bronchi, and its situation has been determined by the aid of the laryngoscope or other means, then an operation for its removal should at once be performed, *although at the time it may not be causing very great distress*. In those cases in which symptoms of suffocation are impending, the propriety of bronchotomy at the earliest possible moment has already been established.

BALTIMORE MEDICAL ASSOCIATION.

[REPORTED BY J. W. P. BATES, M. D.]

Diabetes.

Dr. FRIEDENWALD related the case of a man, *et.* 20, who came under his care to be relieved of a cataract. Upon examination and inquiry he found the man had had diabetes for two years. When first under his care he voided immense quantities of urine, *sp. gr.* 1042; had a ravenous appetite, and an insatiable thirst. He was placed on animal diet, and there was an improvement in the quantity and character of the urine; strychnia was also used. Lately I have given him no special treatment. The urine has gradually decreased from seven pints to three pints; *sp. gr.* 1024. It varies in quantity and specific gravity without apparent cause. Have any gentlemen any experience with the new remedies, as peroxide of hydrogen, in these cases? I did not operate on his eyes, because I feared failure from the want of tone in the system. I should be pleased to receive any suggestion in the treatment.

Dr. MORRIS—I have a case of diabetes, which I regard as incurable, in which I have used everything except the peroxide. At first he voided about two gallons of urine per day. I kept him on animal diet for a time, and then pursued the opium treatment for two months. The quantity of urine is diminished now to less than a gallon, but the sugar is enormously increased. The man is a complete wreck, having lost nearly all his mental faculties. I have tried strychnia, cod-liver oil, skimmed milk, and, in fact, every kind of treat-

ment which promised success. Now I allow him anything he desires.

Dr. UHLER—As Dr. Morris allows his patient to eat anything, I would suggest to feed him on raisins, which may compensate for the loss of the grape sugar carried off by the kidneys.

Dr. HARTMAN—I saw an account of the raisin treatment having been used successfully in France, and it is worthy of trial.

Acne.

Dr. NOEL—What is the best treatment for acne vulgaris? I have had a number of these cases and they are very troublesome. In some cases I have succeeded with arsenic, in others with Summerfield's lotion (sulphur, camphor, lime-water and rose-water). I have a case now, in a young lady, in which I have used potass., iod., arsenic, mercury, etc., without effect.

Dr. MORRIS—The best thing I have found for acne vulgaris is

R. Sulphur,	3vj.	
Glycerine,	3vj.	
Alcohol,	1 3/4vj.	M.

For acne roacea,

R. Potass. acet.,	3vj.	
Glycer.,	3vj.	
Alcohol,	3vj.	M.

Dr. JONES—I have used successfully potass. iod., ac. arseniosi, bitter wine of iron; while locally I used a lotion containing Goulard's extract morph. acet., and glycerine in rose water.

External Perineal Urethrotomy.

Dr. WARREN—About four months ago I was called to see a man who was a martyr to urethral fistula. Some years ago he had gonorrhoea from which stricture resulted; abscesses formed in the perineum, and through these openings the contents of the bladder were passed. It was impossible to pass a catheter into the bladder; a number of surgeons had made the attempt and failed. He was much emaciated and suffered intense pain at every attempt to empty the bladder. So deplorable was his condition that he had been confined to his room for a number of years. Viewing all the circumstances of the case I thought external urethrotomy offered some hope of success, although I knew its performance would be difficult. THOMPSON and ERICHSEN say that when performed in cases in which it is impossible to use a staff, it is one of the most difficult operations in modern surgery. Six weeks ago I performed the operation and dissected a new passage to the bladder. The operation was quite tedious, and he was kept under the influence of chloroform for three hours. From the opening in the perineum I passed a catheter into the bladder; on this I passed a groove director and withdrew the catheter; then I introduced another catheter at the meatus and passed it down until it made its appearance at the perineal opening, when I engaged its

point in the groove of the director and thus guided it into the bladder. I allowed the catheter to remain in for three weeks. The wound healed kindly and a speedy success seemed certain, when abscesses formed at various points, one of which, at the junction of the penis and scrotum, opened the urethra. To remedy this I passed a small gum catheter down the urethra and just past the new fistula, and left the case to nature. It has nearly closed; being at first nearly one inch in length it is now not more than 1-10 of an inch. The man has improved in health, can pass his water at will, and retain it. From the previous condition I think I have accomplished a good deal.

Dr. MORRIS.—I can endorse all Dr. Warren has said about the deplorable condition of this man. I have known of the case for years, and think the doctor deserves the thanks of the profession for his perseverance.

Scarlatina.

Dr. WILSON.—I wish to call the attention of the members to the use of cider in this disease. A boy, *set.* 3 years, came under my care, in which the throat symptoms were very alarming, and were

getting worse. In this condition cider was used with marked benefit, and the improvement was rapid. It was diluted at first, and used in such quantities as he could well swallow; afterward it was used stronger and in wineglassful doses. It acts as an astringent, excitant and diuretic.

Dr. MORRIS.—Dr. HINTZE used, twenty-five years ago, rusty nails in cider. In the treatment of scarlet fever I use nothing but acids, as lemonade, muriatic acid and chlorate of potassa. I have long since discontinued the use of diuretics and diaphoretics.

Dr. Warren.—Cider and nails was a favorite remedy for the sequelæ; acetic acid had quite a reputation in dropsy.

Dr. HARTMAN.—In a case of acute Bright's disease following scarlatina, boy, *set.* five, the stomach was so irritable that all medicine was rejected. Finally, I used bitartrate of potassa in milk, or rather the whey sweetened with loaf sugar. Of this he drank freely; the vomiting was checked, and in six hours the kidneys acted freely, and he voided about half a gallon of urine in about twenty-four hours. I used this for nine or ten days, when he was discharged cured.

EDITORIAL DEPARTMENT.

PERISCOPE.

Pouching of the Perineum in Labor.

Dr. SIMON S. TODD, M. D., writes to the *Kansas City Medical Journal*:

A variable and uncertain degree of resistance to the passage of the head is offered by the vulva in all cases; most marked in first labors. Should this resistance be unusual, and persist for a time after the head has reached the floor of the pelvis without a corresponding resistance on the part of the posterior perineum, a bulging of the latter occurs, increasing with each contraction till a *cul-de-sac* is formed, of which the anterior border of the anus forms the central point of depression, and from which the head is not easily dislodged by natural efforts.

We might reasonably expect sometimes to find existing, as accessories to this pouching, a flattening of the sacral curve, or an unusual degree of mobility on the part of the coccyx, either of which lengthens the antero-posterior diameter of the inferior strait and inclines its axis backward. I feel warranted, however, in assigning, as the usual cause, rigidity of the vulva and a yielding tendency of the posterior perineum, accompanied

occasionally by a faulty fulfillment of the movement of extension.

Though writers, so far as I am aware, make no particular mention of this condition, I am inclined to think it is far from being unfrequent, having myself often witnessed it in a minor degree, with resultant retardation of labor. Doubtless every accoucheur has witnessed the same thing frequently in primiparæ, when this pouching was not so fully pronounced as to offer serious impediment to labor or require peculiar treatment; but this exaggerated form, from its liability to result in central laceration of the perineum, or at the least a hazardous delay of labor, merits special notice and demands special treatment.

A case of this kind, most distinct in its features, having recently come under my observation, where labor in the second stage had for several hours been retarded by this pouching of the anus, and was then brought very suddenly to a close by a simple expedient, I am induced to give it publicity:

Mrs. J. K., *set.* 20, Irish parentage, inclined to plethora, in her first pregnancy and in the full enjoyment of excellent health, was seized with irregular labor pains on the morning of December 7th. I was consulted soon after, but as the patient lived out of the way, did not see her till the evening of

the 9th, when, having been summoned about 7 P. M., I found labor fully inaugurated, with a first position of the vertex. The bowels and bladder were in good condition. Regular and efficient pains were now kept up without interruption till three in the morning, at which time the membranes ruptured and the head rapidly reached the floor of the pelvis. Under the vigorous pains which continued the vulva dilated to a diameter of one and a half inches, where it remained nearly stationary for several hours. In the absence of contraction the vulvar ring was soft and apparently dilatable, but when touched immediately contracted upon the fingers, showing great sensitiveness and elasticity, a fact which I had not failed to notice when I first made examination, and which gave repeated proofs of its continuance to the close of labor.

Following the slight dilatation of the vulva which took place when descent and rotation had been accomplished, was a bulging of the posterior perineum, which, increasing with each unabating expulsive effort, soon involved the entire perineum, threatening the greatest damage to the increasingly attenuated tissues which now imprisoned the head. For the first few hours, the pains recurring with satisfactory force and regularity, I rested easy under the belief that the vulva would eventually yield. In this I was disappointed. Chloroform might have been of essential service, and with the forceps would have been but the work of a few moments. Neither, however, were at hand, so I sent for my forceps, and in the meantime gave the woman six grains of tartrate of antimony and potassa, in three-grain doses, with an interval of twenty minutes. This did not provoke even the slightest degree of nausea.

Up to this time I had with each recurring pain given to the perineum the passive sort of support usually advised and practiced, but it did not occur to me that I might with entire safety co-operate actively by changing the direction of the transmitted force, till I discovered an intervening space, readily admitting the point of the finger between the occiput and lower border of the symphysis pubis. Now, I did not do what Dr. BARNES in his "Obstetric Operations" (N. Y. Ed. page 67) advises sometimes to be done at this stage in forceps deliveries, where the extension movement is incomplete, to wit: pass my fingers into the anus to get a point of pressure upon the forehead, for, practically the existence even of the anus was at this juncture, *per se*, a matter of merest speculation, and the forehead was certainly behind where the anus ought to be.

Placing myself nearly in front of my patient (still lying upon her back) I passed the fingers of my right hand behind the coccyx, upon which the fore-

head lay, the heel of the hand resting lightly on the prominent perineum, and awaited the return of pain. The contraction coming on, I elevated forcibly the coccyx and posterior perineum, and was surprised and pleased to note the remarkable change now taking place. The forehead slid quickly over the face of my hand, and the vulva expanded so rapidly that I felt sure the head would be delivered by the current pain. This result, however, was reserved for the next. Still pressing firmly upward as before, I had not long to wait till another forward movement began; the occiput slowly glided up in front of the symphysis, the vulva further dilated, another throe, and the head cleared the outlet, soon followed by the trunk. It was now ten in the morning, seven hours having elapsed since rupture of the membranes. The integrity of the perineum was perfectly preserved, little evidence of exhaustion was shown, and the woman made a rapid recovery.

Though the advice of Dr. Barnes was not intended to apply to cases like the above, I cannot allow the occasion to pass without modestly expressing doubt of the propriety of adopting, under any circumstances, the suggestion of the eminent obstetrician of St. Thomas' Hospital. In this I am influenced by a fear for the safety of the recto-vaginal wall, which is the only tissue between the finger and the foetal head, and which has now become wonderfully attenuated. The danger of rupturing this thin partition *behind the finger* by the forward impulse given, will be fully appreciated when we remember the facility with which the foetal membranes are torn by the finger when stretched to their utmost tension by the liquor amnii.

The peculiarities in this case are instructive. Had I performed this little feat five or six hours earlier, the woman would have been delivered five or six hours sooner.

The Treatment of Suppurating Glands of the Neck.

MR. LAWSON TAIT, in the *British Medical Journal*, makes some remarks on this subject. The routine treatment of cod-liver oil, iron, and quinine, iodine, and poultices, is seldom departed from. Differences of opinion exist as to whether they should be opened early or late, or not interfered with at all; but whichever way this part of the treatment is conducted, the same unsatisfactory ending in a disfiguring cicatrix is the inevitable result. The "look" of the thing is bad, and from the popular notion that every scar on the neck indicates "scrofula," many a poor mother's life has been embittered, many a poor child's prospects seriously interfered with, owing to the ineradicable neck mark. This objectionable condition may be

avoided in very many cases by careful perseverance in a plan of treatment which Mr. Tait states he has adopted for many years. It consists simply in tapping a gland as soon as it is ascertained to contain pus, and in continuing this treatment until the cavity no longer secretes. The means with which he effects this, is the little instrument known as Dr. ALEXANDER WOOD'S Morphia Syringe. Only two precautions are necessary, and these are, never to introduce the needle twice at the same spot, and to introduce it very obliquely into the abscess, entering it at least a half an inch from the margin of the tumor. As a rule, the direction must be from behind, forward; but occasionally it may be done from before, backward, or at right angles to this direction. He has had to persevere till he has made as many as fifty punctures at intervals from one to ten days before the treatment was successful; the success being constituted by the complete disappearance of the tumor without the skin ever breaking. The amount of satisfaction the patients express at being saved the disfigurement of a gland-mark amply repays in thanks the great amount of trouble required.

Treatment of Bronchocele (Goitre) by Electrolysis and Subcutaneous Injection of Iodine.

Dr. WAHLTUCH records a case of a young lady who had suffered from bronchocele for four years, and had used iodine freely, both internally and externally, without experiencing relief. The size of the tumor was that of an egg. Dr. Wahltuch at first ordered bromine internally and externally, but, as no benefit accrued, he commenced, on July 14th, the electrolytic treatment, beginning with eight Daniell's elements, and the insertion of one needle, and gradually increasing to sixteen Daniell's elements, and the insertion of four needles at first twice a week, then once a week till January 5th. The mode of operation was that the needle connected with the negative pole of ALTHAUS' permanent battery was inserted into the tumor, the circuit being closed by placing a moistened sponge connected with the positive pole to the skin of the neck. The current was allowed to act at first for three minutes, but the time was gradually increased, until it amounted to an hour. The tumor after each operation became softer, and began to swell; the enlargement continued for twenty-four hours, after which it gradually subsided to a size below its previous dimensions. After the twenty-fourth operation the tumor had diminished to the size of a hazel-nut, and consisted of the right lobe alone, the left and middle lobe having been reduced to their normal size. Further operations caused no more reduction, and all treatment was discontinued for six weeks, during which time the size of the tumor

remained unchanged. The hypodermic injection of iodine tincture into the enlarged right lobe was then tried. The injection consisted of one minim of tinct. iodine in nine minims of water, then two minims with eight, and so increasing its strength till twenty minims of the pure tincture were injected at least twice, with the best effects, the tumor disappearing altogether at the sixteenth operation, at intervals first of a fortnight, and then of a month.

Treatment of Diphtheria.

Dr. STEINER, quoted in the *Practitioner*, states that in his opinion we are not at present in a position to determine whether diphtheria is a constitutional and blood disease, or whether it is only a local affection. He appears, however, to be himself inclined to regard it as of a parasite nature, since the methods of treatment he has adopted are chiefly local, with the exception of the administration of the chlorate of potash and quinine. The means employed consisted in the application by gargling, inhalations, penciling or powdering, of the following agents: 1. Aqua calcis in fourteen cases. Of these, nine terminated favorably, five fatally. The solvent action of the lime-water on the diphtheric slough was very well marked. The false membranes had, in a great measure, or entirely, disappeared in the course of six or eight hours. It did not prevent the adoption of other measures. It did not appear to be capable of limiting the diphtheritis to the fauces or to prevent its extension into the larynx and bronchia. 2. Acidum lacticum. This remedy, which was first suggested by A. WEBER, as a solvent, for the false membranes found in croup, was applied by Steiner in the form of inhalations (15 to 20 drops of lactic acid being contained in one ounce of water), but with the same unsatisfactory results as in lime-water. Of seven cases three recovered and four died. Lactic acid must be admitted to effect a speedy detachment of the diphtheritic membranes, but no greater power of arresting the progress of the disease can be attributed to it than to the preceding remedies. 3. Ferrum sesquichloridum (applied with a brush to the parts affected). The solution and separation of the false membranes did not occur so rapidly as after the other means, but, when once this had been accomplished and the chloride was brought into direct contact with the ulcerated surfaces, the latter appeared to assume a healthy aspect, and the process of healing was promoted. Of four children treated by this method, two were saved and two died. 4. Spiritus vini applied by means of a brush, and also in the form of wet compresses around the throat. No remarkable effect upon the false membranes was observed of three children thus treated belonging to the same family; one died, and two

others recovered. 5. Sulphur sublimatum. Dr. Steiner agrees with HANNER, that the action of flowers of sulphur, if it have any at all, is only that of a slight caustic. The application was made by insufflation, and was repeated every three or four hours. Two slight cases treated in this manner recovered; a severe one died. From these experiments Dr. Steiner draws the conclusion that slight cases of diphtheria recover under all of the above methods of treatment; whilst severe ones prove fatal; and that we are not at present in the possession of any remedial agent that is capable of limiting the diphtheric process to the fauces, but that the aqua calcis is perhaps the most valuable remedy, on account of its unmistakeable influence in effecting the solution of the diphtheritic membranes. The plan which he adopts is the following: locally, lime-water; internally, the administration of chlorate of potash, quinine, and wine. When laryngitis appears, he gives emetics; and, in asphyxia, resorts to tracheotomy.

Operation for Strangulated Hernia—Indications that the Sac or Intestine is Exposed.

An interesting paper which appeared in the *Archiv für Klin. Chirurgie*, 1870, has been translated in the *Practitioner*:

The surgeon has the sac before him.

1. When the cellular or fibrous layers divided are thin in reference to the volume and age of the hernia; for a large and old hernia has proportionately thicker layers than one of recent date.
2. When the incision has been followed by a flow of hernial fluid.
3. When the tumor is irregularly depressed and hollowed. This appearance is especially presented by old herniæ, an annular depression being found at the site of the original hernial ring.
4. When a transparent spot is visible, especially at the lower part, indicating the presence of the hernial fluid.
5. When the tumor attains a certain size, and yet presents no appearance of an intestinal loop.
6. When a layer of fat, however thin, exists on the surface of the tumor.
7. When the finger placed in the wound is unable to penetrate to the seat of strangulation. In very acute cases there is sometimes a difficulty, which, however, may be overcome with a little perseverance.
8. When the ring is divided from above downward, the tumor becomes flaccid from the retreat of the intestine into the abdominal cavity; whilst the sac remains outside and presents the appearance of an empty pocket; sometimes, however, the tumor remains without change. In such cases the intestine is strangulated by the neck of the sac and is unable to retreat.
9. When the tumor is devoid of polish, and, notwithstanding the duration of the strangulation, the somewhat pale red of the hernial sac is

not replaced by a livid tint. 10. When with the forceps we are still able to raise thin laminae or filaments from the surface of the tumor, which can never be done from the serous surface of the intestine. 11. When the tumor offers a form which is neither round, oval, nor oblong. In the latter case the sac always contains an intestinal loop.

The operator has the intestine before him.

1. When the tumor exposed is neither nodulated nor uneven, but presents a spherical form, which is sometimes a little oblong or pyriform in inguinal hernia. The surface of the tumor is moreover uniformly smooth.
2. When the hernial fluid has already escaped.
3. When an intestinal loop can be recognized.
4. When, besides the hernial tumor formed by the intestine, portions of the omentum are also present.
5. When the tumor presents a smooth surface.
6. When the color is of a lively red or of a darker red than the sac, when it is not acutely inflamed.
7. When the vessels are somewhat traverse, in the envelope of a hernia they are usually more or less longitudinal. The statement that, when the intestine is exposed, it can be always drawn forward, is erroneous.

The Doctor and the Apothecary.

Mr. WM. L. TURNER gives his views in the *Am. Jour. Pharm.* on this subject, which, as giving the other side of the question, we quote in part:

"The relation to each other of doctor and apothecary has been a subject of considerable comment, generally assuming the character of a two-sided question, the affirmative or negative of which has depended mainly upon the sympathies or pecuniary interest of those who have entered into the discussion. It occurs to mind, however, that it is a question differing somewhat from the one as to 'which side of the jug the handle should be on,' differing in the fact that a third question is necessarily involved. It is no uncommon thing, on the one hand, to hear urged against apothecaries the complaint of 'prescribing over the counter,' as though the pecuniary interests of the physicians were the only matters or interests with which apothecaries had to deal, entirely superseding their own or that of their patrons; while, on the other hand, apothecaries complain of physicians for prescribing special articles and special establishments, as though it were the paramount duty of physicians to see that every one who chose to start a drug store should be properly sustained and supported, entirely ignoring the important fact that those from whom both derive their support, and for whose benefit only either becomes only a useful appendage to society, have rights, which not only entitle them to some consideration in determining this question, but which both are bound to respect; for instance, it is sim-

ply absurd to say that an apothecary should not recommend a simple remedy for a cough, when the person requesting the same can purchase anywhere a remedy for which he has no other guarantee than an advertised list of wonderful cures; or it is equally absurd to suppose that a physician is in duty bound to prescribe only such remedies as he may know or even suppose to be in every drug store, without regarding the requirements of his patient, or his own choice.

But this question of relation to each other does not end here, but assumes another phase, and has become to some extent involved in the issues existing in the medical profession—differences too frequently only of opinion, which, in some instances, have no better foundation on which to build than the hobby of some one remarkable only for having a hobby. There may be those who prefer to be free to act out their part upon the stage of life free from the restrictions or supposed technical proprieties of organized associations, or associated organization, who may by choice prefer, or by necessity be compelled, to work out the problem of life, or ascend the hill of fame, depending exclusively upon their merit or good fortune. There may be others who prefer to surround themselves with such influences and conventionalities as they may deem essential or politic; or deem it of more importance to transmit a fame acquired by others, than acquire fame themselves. What have apothecaries to do with these divisions, that they should array themselves on the side of one and against the other? Is there any necessary connection between the doctors and apothecaries that will justify a sympathy on the part of the latter with any preposterous proposition, or absurd abstraction, that may tend to concentrate the few or separate the many of the former? I know that various attempts have been made to create an impression that pharmacy is merely a collateral branch of, or dependent attachment to, medical science. To such an extent has this attempt been made in some localities that medical men have assumed to prescribe under what legislative restriction pharmacy should exist. This attempt has not been made by medical men only; pharmacists themselves in some instances have taken up the cudgel and battered away in defense of some pet theory of medicine, thus identifying themselves with this, or following in the wake of that, as though it were a proper subject of investigation, where pharmacy should be located or to what subdivision of medicine it should be attached. Is pharmacy to be confined to one or more beaten paths? Shall it be denied the privilege of entering newly opened avenues, and positively forbidden to open itself? As astronomical science knows no bounds, but embraces the universe, so let pharmacists at least regard medical science as embracing all medical knowledge.

Reviews and Book Notices.

BOOK NOTICES.

The Second Annual Report of the State Board of Health of Massachusetts, January, 1871, Boston, 1 vol., paper, pp. 433.

This report is one of the most interesting volumes of its kind we have examined for a long while. The results the Board have elicited, and the suggestions they bring forward, deserve the highest praise for careful accuracy and practical utility. Among the subjects treated are poisoning by lead-pipe used for the conveyance of drinking water; the health of towns; charbon or malignant vesicle; the causes of typhoid fever; homes for the poor; the ventilation of school-houses; air and its impurities; health of minors employed in factories; use of milk from cows affected with foot and mouth disease, etc., etc. On all the topics new and original observations are given, and the whole is presented in a truly scientific manner, unbiased by prejudice or hasty generalization. The Board are doing an excellent work, and we would that every State in the Union issued such a volume every year.

Body and Mind: An Inquiry into their Connection and Mutual Influence, specially in reference to mental disorders. Being the Gulstonian Lectures for 1870. With appendix, by Henry Maudsley, M. D., London, New York: D. Appleton & Co., 1871. 1 vol. cloth, 8vo. pp. 155.

The three lectures embraced in this book treat respectively of the physical condition of the mental function in health. Of certain forms of degeneracy of mind, their causation and their relations to other disorders of the nervous systems, and of the relations of morbid bodily states to disordered mental functions. The appendix contains two essays, one on the limits of philosophical inquiry, the other on the theory of vitality. The whole work bears the impress of vigorous thought and extended research, and though the views of the author are positive, and often peculiar, they are always well supported.

The Rocky Mountain Climate.

The *Laramie Daily Sentinel* says: Physicians and letter writers, by extolling the benefit of a trip to the Rocky Mountains to invalids, have undoubtedly done both the country and the invalids an injustice by inducing persons beyond the possibility of recovery to come here only to die. This deters their friends, of the curable class, from visiting the mountains when many might be greatly benefited. Invalids should not come before the middle of May, and come prepared to remain until the first of January.

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S. W. BUTLER, M. D., D. G. BRINTON, M. D., Editors.

Medical Society and Clinical Reports, Notes and Observations, Foreign and Domestic Correspondence, News, etc., etc., of general medical interest, are respectfully solicited.

Articles of special importance, such especially as require original experimental research, analysis, or observation, will be liberally paid for.

To insure publication, articles must be practical, brief as possible to do justice to the subject, and carefully prepared, so as to require little revision.

We particularly value the practical experience of country practitioners, many of whom possess a fund of information that rightfully belongs to the profession.

The Proprietor and Editors disclaim all responsibility for statements made over the names of correspondents.

THE AMERICAN MED. ASSOCIATION.

In view of the approaching session of the American Medical Association, we offer a few suggestions of topics with which it were desirable to see it occupying its meetings.

The value of a general organization of the kind depends directly upon the effectiveness with which it discusses and elucidates the questions which occupy the attention of physicians in their daily professional life. Its value is decreased when, instead of such subjects, it becomes the organ of cliques, schools, or individuals determined to seek their own ends at all hazard, and interested rather in bringing themselves prominently forward than in advancing the well-being of the entire profession.

The last session that met in Washington City, in 1870, was by no means a creditable exhibition, and left an impression on the public mind more correct than it was admirable. The partisan spirit which was there manifested, the strife for personal aims, the turbulence, the vanity of individuals, the parliamentary incapacity displayed at that time, we stigmatized then, and we hope sincerely not to see repeated.

Even if the temper of the association be such that the delegates cannot discuss calmly and politely some vexed questions—which would not be a praiseworthy frame of mind—they can at any rate find enough besides to occupy their hours with topics, which they could with great public advantage discourse upon.

The organization of local medical societies throughout the States is, by no means, com-

plete. A distinct effort to have every State and every county connected with the Central Association would be a praiseworthy step.

The propriety of a higher culture in medical colleges has often been talked of. It is time now that something real be accomplished.

The degradation of the title of Doctor of Medicine by chartered institutions of a shameless character should be limited if possible.

The importance of the association identifying itself in the movements of State Medicine, especially in the distribution of general knowledge on prophylaxis and hygiene, cannot be over-estimated. As it is, they are sadly neglected.

More direct encouragement of the scientific labors of the sections would redound to the credit of all concerned.

The relations of physicians to apothecaries ought to be more clearly defined.

As to discussions of minute changes in the code of ethics, they are usually idle and unnecessary. The elaborate revisions which this code has undergone are enough, without making it the vehicle of narrowed and prejudiced views.

On account of the severe illness of the Senior Editor of the REPORTER, and the failure of receiving proof at the office, we must apologize to our readers for the appearance of the last number.

We hope never again to see such a specimen of negligence leave our office.

Correspondence.

DOMESTIC.

A Suggestion.

EDS. MED. AND SURG. REPORTER:

Malignant growths, or cancers, are now, and always have been, a source of interest to the profession, and a standing reproach in our present state of knowledge concerning them. Who is he that understands their nature? Pathology teaches that they are abnormal cell-growths or developments. What then? Who knows the cause of their production, or the peculiar state of the solids and fluids that is favorable to their formation? Or the more important point, who knows how to cure them? To read the public prints, we might suppose that certain gifted individuals can at all times cure them for an equivalent in money, and have a complete mastery over that state of the human system that

is favorable to their reproduction, and yet they are not cured. Surgery has hitherto failed, and continues to fail. Quackery alone pretends to possess the means of never-failing cure. Still the disease is developed, and the unfortunate patient languishes, suffers and dies. Scientific men propose remedies, and they are tested, and successively fail, and are cast aside. Has there been a chemical analysis of the diseased part? What elements of healthy growths are wanting, and what of unhealthy growth is found to exist? Are we not in the dark? Is there no remedy that will restore and maintain the human body in that normal condition that will be incompatible with the production and development of this fearful disease? I am not competent to answer. But we are taught that a proper proportion of iron and oxygen are essentials of healthy blood; if we have healthy blood can we have cancer, or other malignant growths? I think not. Can we maintain the blood in a healthy normal state by administering to patients afflicted with this malignant disease preparations of tr. ferri. chloridi; and exhibit at the same time such medicines: chlorate of potash, nitric vinegar (vinegar saturated in nitrate of potash) or even oxygen gas? Would not the action of such remedies given freely have the effect to prevent that morbid, depraved state of the blood, without which I think it would be impossible for the disease to exist? This is merely a suggestion; I have no data to produce; but is it not worth trying by those who have the opportunity—medical men in cities, professors, and those having charge of hospitals, etc.?

Oxygen gas might be administered by inhalation, or a jet of it played upon the surface of the sore, after the inflammation and ulceration has destroyed the skin. The use of the above named agents could not possibly do harm, as the disease under present treatment inevitably grows worse and is fatal. Some may object that the use of iron and oxygen would produce violent inflammation. It may do so. What if it does? Would the case of the patient be more critical? May not acute simple inflammation of a cancerous sore bring about a different and more favorable condition of things? Who knows? I have read of tumors being vaccinated with cow-pox matter with favorable results, and if a different state of affairs could be brought about in the disease in question, might not the final result be fortunate? If it done no good (the treatment, I mean,) it would not be any worse for the patient afflicted with this horrible malady, for he has to die under all known treatments.

I hope some of my medical brethren will give this matter a fair and impartial trial, test it thoroughly and without prejudice, and let the result be known. All great discoveries have mostly been accidental and unlooked for. Understand, I do not claim this as a discovery, but merely a suggestion that has occurred

to my mind, and has recurred until I felt it my duty to bring it forward in some shape before the medical world for their investigation and trial, for I am so situated that, if I had a patient laboring under this form of disease, I could not thoroughly and satisfactorily apply it; but my mind has been so much impressed with this idea lately that I could feel satisfied with myself only by making it public.

Some may sneer and think I seek a degree of notoriety. Such is not the case; and if this suggestion is valueless, or has been tried and found ineffectual, set me down as a visionary, who only meant to diminish the amount of human suffering in existence, and ameliorate the condition of his fellows. And if the proposed treatment should prove effectual, let me have the benefit of suggesting it; if no one can prove me wrong in this matter, let them weigh it honestly and candidly, and with the spirit in which these broken hints are written.

F. A. ROOP, M. D.

Galestown, Md.

A Novel Case.

EDS. MED. AND SURG. REPORTER:

On the 19th of June, 18—, I was called to see Mrs. B—, æt. 44, mother of some eight children, youngest some five years old; found her busily engaged in household duties. I inquired the cause of her summons to me; she replied that she was about seven months gone in pregnancy, but had felt no movement of the child for about two weeks, had not had any chills, no hemorrhage, felt well, but was satisfied that the child was dead, and only wished to know what she ought to do. I told her not to concern herself about the case, that the uterus would in time expel the fetus—how soon I could not tell—but to inform me if anything unusual should happen, or there were signs of labor.

I heard no more of the case until the 15th of August, the expiration of the nine months pregnancy. I was then called to see her; found her in labor; said she had felt no movement of the child since my former visit. Labor progressed favorably, until the birth of the dead, unsightly fetus. I waited a short time for uterine pains; there were none; no hemorrhage, not even a "show." I decided on removing the placenta. The cord being small and tender I could use no traction; it only served as a guide. Upon making the usual digital examination, I could not reach any placenta, or the point of attachment of the cord. I waited a short time, as I could in all safety in this case; I then passed my hand into the uterus, following the cord to the fundus, but found no placenta; the cord had its attachment to what seemed to be the uterine wall—the surface of the womb at this point of attachment seemed to be in a nodulated

condition; for at least one inch each way from this point of attachment, these nodes were the size of a garden pea. I then withdrew my hand, leaving every thing as I found it. I thought it over; made a second exploration; the same result. I then informed those present of the state of things (new to me).

The second or third day after delivery the umbilical cord sloughed off and passed away—no lochia, not a single unfavorable symptom in the case afterward. The only plausible theory I have on the subject is, that degeneration of placenta took place, causing the death of the child; and during the two and a half months after its death the placenta was taken up by absorption. If any of your readers have met with such a case, I would like to hear from them.

J. CARY, M. D.

Uniontown, Pa., March 24, 1871.

Renal Disease.

EDS. MED. AND SURG. REPORTER:

Cases reported in medical journals are apt to be like cases reported in medical societies. They are cases that have all or nearly all recovered. Now I propose reporting one that did not recover, for two simple reasons: First and least, I wish to see how the report of a case that *died*, would look in a medical journal (especially a case that did not originate in San Domingo, South America or New Zealand, and died in a New York or Philadelphia hospital, a case that all "country doctors," like ourselves, are liable to run against at any time, and one that throws them back upon that basis peculiar to "country doctors" (I mean self-reliance and practical good sense). My second reason is, trusting that it may call out from some of our professional brethren their opinions as to the cause of the suddenness of the attack, and its rapid course to a fatal termination; also what treatment could have been adopted different from the course pursued, if any, with any better prospect of success. But I hasten to the case. I was called on Tuesday, the third day of January last, in consultation with Drs. McKELVEY and REBER (the two leading physicians of this town), at the house of Mr. A., in the case of his son, a boy 14 years of age, who had been perfectly healthy as far as known up to Thursday, the 29th of December, when he noticed that he was "urinating more than natural." He had been attending school up to that time. The following day (30th) he felt somewhat weak and quite thirsty, but still was about, and went out to the iron mines, a half mile. That night, for the first, he had to get out of the bed to urinate.

On Saturday he went to his father's barn and harnessed a team of horses, intending to drive some

five miles, but being a cold day, and passing so much water, abandoned the idea; he then complained of feeling weak and thirsty; that evening sent to town for Dr. Reber, who at once diagnosed the case as one of saccharine diabetes, which a chemical analysis confirmed. Passing a large quantity of pale, greenish urine of a sickish, saccharine smell. Pulse, 130; tongue slightly coated; still complaining of nothing except thirst and a feeling of weakness.

Sunday, Jan. 1st. For the first time confined to the bed; pulse, 130; tongue coated, somewhat dry; skin dry and hot; thirst excessive; passing seven quarts of urine every 24 hours; returning an acid reaction; density 1,050. Doctor continued tonics; tinct. fer. chlo., quinia, etc.; also, opii and alkalies, beef tea, and milk as diet.

Monday—Very slight, if any improvement; doctor continued the treatment with sponge baths; bowels slightly relaxed; skin not quite as hot; urine the same, except neutral.

Tuesday—Visited him in connection with Dr. R., and also Dr. McK. Pulse, 140 and weak; skin cool but dry; tongue dry and dark; urine the same as before; no acid reaction, but density of about 1,064; pupils rather sluggish. At the suggestion of Dr. McK., creasote was added to the treatment. That evening he died, no *post-mortem* was allowed, but no physical or rational symptoms ever indicated any complication. Query—What caused this sudden attack? What caused this rapid progress? What else could have been done to arrest its march? Has any professional brother met with a similar case?

FAGG.

Bloomsburg, Pa., March 30, 1871.

Fracture in an Aged Person.

EDS. MED. AND SURG. REPORTER:

The results of the following case may be interesting, proving that extreme old age is not a prevention to the formation of callus.

Mrs. Robert Steel, *æt.* 91 years, fell March 20th, 1860, and fractured the upper third of right femur. The bone was broken nearly transversely, caused by striking the rail of a low bedstead in the act of falling. I at once applied *Physic's* splint, but in less than two weeks had to remove it, owing to the pressure interfering with the circulation and causing extensive ecchymosis.

Counsel was now called, when it was agreed to abandon all dressing and aim merely to comfort and palliate the patient. A trial of a few days without any dressing proved to be more painful to our patient than with the splints applied. I now substituted for dressing six narrow, short splints around the fracture, held to the limb by adhesive straps, and made extension per weight (six pounds of sand)

with pulley and adhesive straps. This appliance was continued for seven weeks, when good union had taken place. Thirteen weeks from the time of injury Mrs. Steel walked about in her room with a well united limb, osseous union having taken place. There is one and a half inch shortening. Mrs. Steel is now 93 years old and enjoys good health.

J. K. HOLLOWAY, M. D.

Akron, Ohio, March 14, 1871.

Wash for the Cure of Poison from the Poison Oak.

EDS. MED. AND SURG. REPORTER:

Having noticed a communication in the REPORTER for March 4th, 1871, from Dr. DUNN, of La., in reference to his treatment of poisoning from poison oak, I will give the result of a large experience in the treatment of this annoying affection. Children are very liable, when running with bare feet, to tread upon this shrub; a touch with the hand or any part of the person is quite sufficient to produce the characteristic sore. There is no necessity of treating this trouble constitutionally, the writer having always succeeded in effecting a cure in the following manner:

R	Hydr. bl. chlor.,	ʒss.
	Distilled water,	ʒiij.
	Add and dissolve	
	Mur. Ammonia.	ʒj.
	Nitrate potassa,	ʒij. m.

Apply thoroughly three times per day with a camel's hair pencil until the parts affected are inflamed in consequence, then discontinue it for a few days, using instead calomel ointment, U. S. P., until the parts are healed. I have rarely had occasion to repeat the wash.

JAMES S. BAILEY, M. D.

95 Eagle Street, Albany, New York.

Chloral in Infantile Epilepsy.

EDS. MED. AND SURG. REPORTER:

About the 20th of January last I was called to see a child of African parentage, which was born December 27th, 1870. It was having convulsions every few minutes, but not very severe. I prescribed bromide potassium and bromide ammonium in two grain doses three times daily, alternated with quinine and Dover's powders, and in ten days the fits ceased.

February 3.—The convulsions returned. Renewed the same medicines, but with no benefit. Next day prescribed

R.	Chloral,	ʒj.
	Syr. simp.,	ʒiij.
	Spts. etheris comp.,	ʒj.
	Syr. zingiberis,	ʒij.
Sig.—	¼ teaspoonful ter in die.	M.

February 10—Convulsions ceased on the 7th; to continue the chloral and powders.

February 16—Slight return of the paroxysms.

February 20—No return for three days.

February 26—Had one or two slight convulsions. Prescribed castor-oil, and ordered continuance of the chloral mixture.

March 22—Called and found the child had entirely recovered. No indication of fits since 28th ult.

The mother had continued the mixture twice a day through the month, having procured a repetition of the prescription as required on her own responsibility. The child is fat, and in every way healthy.

I will add that the mother buried an infant last summer, which died from cholera infantum, and had convulsions during its last hours.

The grandmother believes in maternal influence upon the fetus in pregnancy.

F. K. BAILEY, M. D.

Knoxville, Tenn.

NEWS AND MISCELLANY.

Railway Compensation.

In an important railway case in England, tried lately, the Lord Chief Justice said that he was in the habit of suggesting, in actions on account of railway accidents where there was a conflict of opinion between the medical men as to the period of the sufferer's recovery, that a maximum sum should be given on the worst view of the case, to be reduced *pro tanto* after an examination by a medical man at the end of the period named for probable recovery, if the patient were in a better state of health; but that, if he remained in the same state, then the damages should stand. Mr. Chambers said he thought it a good suggestion; and it was adopted.

—Dr. W. T. TALIAFERRO, one of the oldest physicians of Cincinnati, died March 22, in that city, aged 76. He took part in the war of 1812, and was in the battle of Lake Erie.

—Prof. VON NIEMEYER has been appointed to the Clinical Professorship lately occupied by Prof. SKODA, who has resigned.

—The library of the late Prof. VON GRAEFE has passed into the hands of a bookseller, and will be sold. It is exceedingly rich, both in ophthalmological and general works.

—The Home Secretary has intimated to Dr. LYON PLAYFAIR, member for the Edinburgh University, that he will submit the name of Mr. GEIKIE, F. R. S., to the Queen as first Professor in the new Chair of Geology in that University. This has been done at the express recommendation of Sir ROBERT MURCHISON, who has given the sum of £6,000 to found the chair.